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Boundary Training 104

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Touch

> *TOUCH:* To bring a bodily part into contact with especially so as to perceive through the tactile sense: handle or feel gently usually with the intent to understand or appreciate.
>
> *Webster's New World Dictionary*, 2024

How we're touched, when we're touched, where we're touched, why we're touched, and by whom we're touched—all of these have an effect on how we respond to touch. It is an individual matter based on our gender, on our cultures' attitudes about touch, on our families' attitudes about touch, on our own particular likes and dislikes, and on our particular histories of experience with touch.

Also important is our readiness for touch: Is this a context in which we expect to be touched? Wish to be touched? Are we feeling uneasy? Vulnerable? Needy? Sensual? Have we been getting enough touch lately? These are all factors that influence our response to touch. In the healthcare relationship, touch is extremely complex. In fact, it is an aspect of practice that we cannot 'just do it' without giving quite a bit of thought to. We cannot know our patient's experiences with being touched and whatever experiences we've had regarding touch may require some time to recall. As much consciousness about touch as possible is important to our practice. This is why we will be considering different aspects of touch in this section.

"Touch is a powerful tool in healthcare, conveying empathy, comfort, and support. But it can also be easily misinterpreted or experienced as a boundary violation. Before engaging in physical contact, consider the clinical necessity and the patient's comfort level. Explain your rationale and obtain consent. Be attuned to cultural and individual differences in attitudes toward touch, and document any unusual reactions or concerns."

Tong Law Website; "Maintaining Professional Boundaries in Healthcare: Guidelines for Practitioners"; 2024

"Touch is one of the most essential elements of human development, a profound method of communication, a critical component of the health and growth of infants, and a powerful healing force."

To Touch or Not to Touch: Exploring The Myth of Prohibition on Touch in Psychotherapy and Counseling Clinical, Ethical & Legal Considerations; Ofer Zur, Ph.D. & Nola Nordmarken, MFT; 2017 Zur Institute Website[1]

PERCEPTION AND TOUCH

The skin represents much more than just an integument designed to keep the skeleton from falling apart…it is in its own right a complex and fascinating organ. In addition to being the largest organ of the body, the various elements comprising the skin have a very large representation in the brain, based on Ashley Montagu's book "Touching: The Human Significance of the Skin" (New York: Columbia University Press, 1971), 6.[2]

The touch sense provides each of us with a tremendous amount of information, but significant differences exist in how that information is used and interpreted, mostly below consciousness. There are individuals who are sight-oriented and those who are touch-oriented, according to Montagu. The discipline of Neuro-Linguistic Patterning (NLP) adds a third category, "auditory," for individuals who are hearing- oriented. These are the ways in which we receive information, the sources of information upon which we rely.

The three primary methods through which we receive, and process information are:

- Sight
- Touch
- Hearing.

Someone who is primarily touch-oriented, or "kinesthetic" in NLP jargon, will perceive a wider range of subtlety of tactile sensation when touching or being touched than will someone who is primarily a visual or auditory person. Often this perception is below the level of conscious awareness, so that the individual is left with "feelings" about the experience. If the person who touches another is having sexual thoughts and feelings, or has any other hidden agenda, this may be picked up by the individual who is being touched. Another possibility is that the individual may believe there was an intention other than what the provider intended.

This is a good reason to have charts in each room that indicate the areas of the body we will be touching and why and then to ask permission to proceed. It is always wise to check a person's body language who we are working on as to whether or not they are comfortable, or to even ask if they have any questions.

Someone who is visually oriented may be especially likely to perceive the corresponding nuances of body language, whether consciously or unconsciously. Likewise, someone who is hearing-oriented, or auditory, may be especially good at reading tone of voice for its conscious and unconscious messages.

But while some of the differences in the way and the extent to which we perceive touch may be innate, others may be learned or conditioned. People who are awkward and clumsy in their physical interactions with others may have been raised in a family where there was little touching, or they may have lacked closeness with one or more of their parents. Such early experiences can affect people for a lifetime and of course, have an impact on the provider/client relationship.

TOUCH AND GENDER

"Survivors of trauma, including sexual assault, have higher rates of anxiety and are less likely to engage with the health care system than the general population. Pelvic exams in particular can seem unbearable to some people. An uncomfortable or traumatizing visit to the doctor can turn the health care system into an intimidating entity and prevent people from receiving the care they need."

Pasricha, T. (2023). "When therapeutic touch isn't healing". Harvard Health Publishing, Harvard Medical School website.

Some of us may lack a repertoire of non-sexual, nonviolent touch, and may not even recognize its existence. To some of these individuals, touch might be perceived as either an attack or a come-on. It is for this reason that it would be wise when we to begin touch any patient, we do so with caution and awareness.

For women in our society, touch is a more important part of sexuality, but it is also likely to be a more important part of caring and communication. They are more likely to have, and to expect, a broader repertoire of touch.

For those who are 'other', there may or may not be some melding of the two genders in terms of their response to a provider's touch. Again, always explain first, proceed with a light touch, and watch body language.

There is a correlation between a lack of appropriate, affectionate touching in early childhood and violent behavior in later life.

Early socialization probably plays a role in these gender differences, which are much less

noticeable in other cultures. From birth, babies in our society tend to be given less affectionate touching if they are boys, more if they are girls. Interestingly, a lack of affectionate touching in infancy and early childhood has been linked with higher rates of violence and aggression in later life.

But as great as the gender differences in early touch may be, they pale beside the differences that are found from one family to another. One family may be very physically demonstrative; in another, days may elapse without any touch between most family members.

TOUCH AND CULTURE—High Contact Cultures and Low Contact Cultures

Just as there are families in which there is minimal touch, so there are cultures in which there is little or no touch. In the United States, this can be seen in the difference between the culture of the North and the South, or in the differences exhibited by members of different ethnic or immigrant groups. The amount of personal space with which people feel comfortable and the amount of eye contact they employ in different situations also varies from culture to culture. It's wise to have an understanding of high and low touch cultures. Latin and Mediterranean cultures tend to be more high touch cultures. When we know where someone is from, we can use that information to be more cautious or not with touch. However, women from high touch cultures may not be as comfortable as males with touch.

"Low-contact Cultures"
"Cultures in which people tend to touch each other less often than is usual in most cultures, maintain more interpersonal distance, face each other more indirectly, have less eye contact, and speak more quietly. For example, China, Japan, Norway, Sweden, and Finland."

Oxford Reference website; 2024.

The Japanese strove to maintain, at least through the 1960s, constant contact with their children. Whole families would bathe together. Japanese infants generally received, and continue to receive, a much greater quantity of affectionate touch than do most American infants.

The University of Miami's Touch Research Institute, has examined common touch practices around the globe and has created two classifications for countries: "high touch," such as France, Italy and Greece, and "low touch," including New Zealand, the United States, Australia, and Great Britain. The institute's researchers established a worldwide correlation between high-touch cultures and low rates of suicide, abuse and depression. They cited Italy, among others, as an example of a "high-touch" culture with a low suicide rate.

Obviously, rates and uses of touch vary across different ethnic groups and cultures. As a medical practitioner, it is critical to understand and be aware of the cultural differences that exist in our use and perception of touch. As we see - and touch - patients from different cultures and backgrounds, we need to be mindful of what messages our touch (or lack of touch) might be conveying.

Assignment #1

In this assignment, we will be asking you to consider the various cultures in your practice area. Please take out a piece of paper or open a new document and answer the following questions.

1. Write down the countries your patients come from.
2. Write down the countries that are represented in your area.
3. Are you familiar with what these various cultures' ideas and beliefs are about touch?
4. Are you aware of these cultures' ideas about touch between genders?
5. Do you know what these culture's ideas are about healthcare providers touching and caring for patients?
6. Are you aware of the ideas about a provider of one gender touching a patient of another or the same gender?

Since the U.S. is considered a non-tactile society, it will behoove practitioners to use caution before touching patients. Being aware of personal space, cultural differences and the gender of our patients is wise. The more we understand about those patients who come to us from other parts of the world, the better. This is because their cultural ideas about what kind of touch is appropriate for which people and under what circumstances, will help us to care for all people.

TOUCH, PROXIMITY AND INTIMACY

Touch affects each of us deeply. It is a creator of intimacy. It is a means of communication. It is a part of many social interactions. But, until recent years, the many roles of touch had received little attention from Western science. This is particularly unfortunate given the explosive, emotional charge that touch may carry in a society like that of the U.S. where non-sexual touch is a rarity and where any touch can engender feelings of danger.

> *America is what anthropologists call a "nontactile" society. Compared with most cultures, we are—so to speak—touchy about touch. When psychologist Sidney Jourard observed rates of casual touch among couples in cafés around the world, he reported the highest rate in Puerto Rico (180 times per hour). One of the lowest rates was in the U.S. (two times per hour).*
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> *"[Touch Research Institute psychologist Tiffany] Field has discovered that French parents and children touch each other three times more frequently than their American counterparts, a pattern that continues with age. At McDonald's restaurants in Paris and Miami, Field found that French adolescents demonstrate significantly more casual touching—leaning on a friend, putting an arm around another's shoulder. American teenagers were more likely to fiddle with rings, crack their knuckles and engage in other forms of self-stimulation. "French parents and teachers alike are more physically affectionate and the kids are less aggressive," says Field."*

George Howe Colt, "The Magic of Touch: Massage's Healing Powers Make it Serious Medicine," Life (August 1997), 62.[3]

Just the nearness of one person to another—a prerequisite of a physical examination and of many treatments—creates a sense of artificial intimacy that must be handled with care. This is particularly true in the United States and Canada, where in many regions it is rare for people to come within arm's length of one another in business and social situations. The amount of "personal space" that people require in order to feel comfortable varies by region, by culture and by situation. In fact, an entire branch of study, called proxemics, is now devoted to evaluating the use of distance in social interactions.

In the Middle East and Latin America, people commonly station themselves within one or two feet of one another, instead of the customary three or four. And, in a family setting or in the anonymity of a crowded bus or stadium, more closeness is tolerated by most cultures. However, the level of closeness created in an exam room between a patient and a medical professional is rare outside the bedroom. Training concerning how to handle such professional intimacy is long overdue.

TOUCH BETWEEN PROVIDER AND CLIENT

> *"The right type of friendly touch—like hugging your partner or linking arms with a dear friend—calms your stress response down. [Positive] touch activates a big bundle of nerves in your body that improves your immune system, regulates digestion and helps you sleep well. It also activates parts of your brain that help you empathize."*
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> Meghan McClusky; TIME website; April 10, 2020; "The Coronavirus Outbreak Keeps Humans from Touching. Here's Why That's So Stressful"

Touch generally involves the client giving up power to the practitioner. Here, however, is the story of someone who turned the tables, using touch to take back power over his situation:

> *On the morning after his ten-hour operation, Chuck awoke to a web of tubes. Ominous whispers could be heard outside his room. Then the medieval procession known as grand rounds began, and seven sober residents and interns, clutching clipboards against their chests like dueling shields, entered his room single-file and circled his bed.*
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> *Chuck's wife, Peggy, felt violated for her husband—he seemed so vulnerable and exposed—but his first words let her know he was still fighting for control. "You have to understand," explained Chuck, "anyone who works on me has to touch me." Chuck then reached out to the Chief, who took his hand and held it. Chuck extended his other hand to an intern saying, "That means everybody." Like awkward schoolchildren, they looked to their Chief for permission. Next, an intern stepped forward, introduced himself, and touched the patient. Chuck responded, "Good, that may be the best medicine you'll ever dispense."*
>
> Colt, "The Magic of Touch," 60-62.[4]

Touch is a way of showing concern. And touch is a form of communication. These qualities of touch can allow for closer connections in the healthcare relationship—when touch is used appropriately, and with both awareness and consent on the part of the client.

As medical professionals, we may find ourselves tempted to compensate for our patients' lack of satisfactory childhood touch. And, if our own early touch experiences were not sufficient, we may also feel a need to compensate for that lack in some way. Some say that our Western society is suffering from a touch deficit. Clearly an office setting is not the place to satisfy that and attempting to do so can become problematical.

> When performing a procedure requiring touch, ensure your client understands at all times what is being done and why.

Procedures requiring touching of patients are very vulnerable to misinterpretation. Ensuring that patients understand at all times what is being done, and why, will greatly reduce the risk of offense.

Healthcare workers would benefit greatly from educating themselves about the aspects of touch that can affect the provider/client relationship. It is for this reason that we have devised the Safe Touch Protocol (see later courses in this series).

What do professionals need to know about touching? Whenever we reach out to touch someone, there are a number of points to consider:

- Good intentions are not enough.
- You may never know how the use of touch in a person's family, and in their culture, has shaped their perception of touch.
- You may never learn about an individual's history with other providers, whether positive or negative.
- Your own family and cultural background will have a bearing on how comfortable you are with touching others and on how others will perceive your touching.
- You will be affected by—but may not be aware of—your own needs regarding touch during the time you are seeing the patient.

All of the above will have a bearing on how comfortable you are with touch and on how your touch will be received and perceived. But remember, some of our most intimate times involve being touched, so when a person is touched by someone whom he or she barely knows, some unusual reactions can be expected. Because we will rarely know the specifics of anyone's past experiences, we will need to use all of our verbal and nonverbal skills to assess their needs. By employing sufficient sensitivity, we will be able to make an educated assessment of how to proceed with touching each individual.

We also need to be very aware of the skills and attitudes that we bring to touch. When we touch, we give very clear messages—including some messages of which we are aware, and some of which we are not.

Assignment #2

Please take out a piece of paper or open a new document and answer the following questions:

1. Consider the patients who are now coming to you.
2. Write down the names of any who you think might need to care for in a more gentle or careful manner.
3. Next to their names, write any ideas you have about how to approach touching these patients going forward.
4. You might want to take more time explaining what you are doing and why.
5. Perhaps when you begin touching them, watch their body language for signs of comfort or lack of comfort with your touch/procedure.
6. Take this paper with you when you next go to the office so that you may apply your thoughts from this assignment.

Kinds of Touch Explored

There are many kinds of touch, many perceptions of touch, many ways to touch, and many intentions in touching. Some are appropriate in the healthcare relationship, and some are inappropriate. All healthcare professionals would be wise to be aware of the power of touch and especially our particular repertoire of touch. Since there are so many kinds of touch, methods of touching, and ways of perceiving the touch that is received, it is not always possible to predict what the effects of touch will be.

Perceptions of Touch. Each instance of touch will be perceived by the individual being touched as having certain qualities: firm, soft, hard, painful, gentle, soothing, rough, careless, sensitive, insensitive, assertive, dominating, submissive, half-hearted, tentative, assured, deliberate, icky, wishy-washy, clammy, gripping, prodding, poking, unwilling, jabbing, jolting, cold, warm, passionate, respectful, disrespectful, trembling, uncertain, stroking, hesitant, groping.

Intentions of Touch. Note that the *intention* may be very different from the *perception*. If the intention is strictly procedural, but the individual feels improperly cared for, you may have a serious communication problem and even possibly a lawsuit on your hands. Examples of appropriate and inappropriate qualities of touch are presented in Table 3.1.

Uses of Touch. Just as many practitioners assume their clients' perception of a touch is interpreted the way it was intended; some providers also mistakenly assume that they *know* what effect their use of touch may have on patients.

Table 3.1 Appropriate/Inappropriate Touch

Appropriate Qualities: *Respecting boundaries*	**Inappropriate Qualities:** *Violating boundaries*
Comforting	Sexual
Caring	Insensitive

Deft	Clumsy
Procedural	Haphazard
Healing	Hurtful
Supportive	Brusque

Examples of touch gone wrong

- *A chiropractor in Ontario reports that he used to routinely pat his patients on the rear to signal that he wanted them to turn over—until a patient told him how she had left another chiropractor because he did that. That was a rude awakening for the practitioner, who then altered how he requested people turn over. When asked about their experiences with provider touch, people were quick to complain of cold hands and cold instruments, especially if either had been wielded by a gynecologist, urologist, or proctologist.*

- *Some spoke of being startled by practitioners who, while out of sight, gave no warning of their intentions. One told of an orthopedist who didn't know when to quit: The doctor's forceful examination of an injured knee was causing the patient a great deal of pain. "Stop. Stop it. Stop that, right now," the patient demanded. But that demand was neither heeded nor acknowledged until the patient—by now, in tears—bellowed, "Stop, or I'll sue!"*

- *Some people described behavior that was decidedly inappropriate. One told of a physician who never mentioned an antibiotic without discussing its efficacy for venereal diseases, and whose crotch pressed against the patient whenever the doctor measured blood pressure, listened to chest sounds, or peered into a sore throat. Despite the many free samples, that doctor now has at least one fewer patient.*

- *Another patient talked about a chiropractor who was competent, cute, charming, and friendly—a little too friendly. At first, the jokes and chit-chat were comforting, the patient recalled. But by the third or fourth visit, things seemed a little too intense, "almost like he was flirting with me," and she began to feel uneasy around him. One day, as she lay face down on the table, he tickled her with the tip of her long braid. "What did he think he was doing?" she said. "He's supposed to be a professional. And the way he kept looking at me and talking to me…I think he was flirting with me. What am I saying? I know he was flirting with me. I just didn't want to believe it. He was flirting with me. And I didn't like it."*

- *Several other patients spoke of problems with touch that, though also inappropriate, they believed to have been accidental. One woman told of the gynecologist whom she abandoned after a single pelvic exam, during which the doctor was all thumbs, and those thumbs kept bumping painfully against her clitoris.*

- *Two others described problems with dentists or orthodontists who—while working in their patients' mouths—failed to keep sufficient track of their own arms. Both women mentioned the discomfort and embarrassment they*

had felt as the dentists' elbows or forearms repeatedly brushed their breasts.

Assignment #3

Please take out a piece of paper or open a new document and write down the answers to the questions below.

1. How do my patients perceive my touch?
2. How do they feel about my use of touch?
3. Am I using touch in ways that make people uncomfortable?
4. Could I alter my touching in any way to ensure that more of my patients will feel comfortable?

Feedback about Touch

Sources of such information can include direct or indirect patient comments to you or your staff. This feedback could be very indirect; for example, whether a patient returns, or whether a patient refers other people to you. An anonymous survey can be very helpful in soliciting more direct feedback. A patient questionnaire and sample cover letter for current and former patients are included in "Safe Practice Analysis"—a part of the Patient Protection Protocol that is presented in later courses in this series.

Negative feedback can be difficult to deal with. But when you know how clients truly feel, you will have the opportunity to assess yourself and to make any necessary changes. This is far superior to merely wondering or assuming. To make procedural touch safer and more comfortable, we have created guidelines for safe touching. These can be found in later course in this series.

Effects of Gender and Sexuality

Substantial gender differences have been found in the use of touch and proximity in the healthcare relationship. Men in our society have been socialized to see touching as a means of obtaining sex or enforcing power; this discourages the use of casual touch in conversation. They may see proximity as a threat to their autonomy and eye contact as a challenge to their dominance; this discourages the use of either in non-confrontational situations. Women, on the other hand, have been socialized to think of touching as a means of conveying support or sympathy; they use more touching in their conversations. They have been socialized to see proximity and eye contact as a means of establishing a valuable interpersonal connection. They, therefore, are likely to be comfortable with more eye contact and closer interpersonal distances.

These are only generalities, however. The reality is that attitudes toward touch, proximity and eye contact vary more from culture to culture, or family to family, than from gender to gender. They are shaped by genetics and early childhood experiences and are influenced by the events of a lifetime. There is no substitute, therefore, for careful observation of each patient's responses.

Touch, Connection, and Power

When a client needs to connect with the practitioner, then more eye contact and a somewhat closer interpersonal distance may be helpful. When the individual is feeling threatened, less eye contact, an indirect posture (that is, not facing the person straight-on), and a greater

distance may be helpful.

A belligerent person may be reacting to a perceived threat to their autonomy; try making eye contact while asking questions, then looking at your clipboard and making notes while they respond. Some will be drawn out by a friendly approach that establishes a rapport, while others will respond better to an impersonal approach that minimizes the power differential. It is vital to make any procedure involving touch as comfortable and as safe as possible. The process will always be one of trial and error, but training and experience will help to minimize the error and maximize the effectiveness.

Explorations and Applications: Gender and Sexuality

Gender, sexuality and touch in the healthcare relationship are issues that have always affected both practitioner and patient, yet until recently, they have often been neglected in the education of professionals. All healthcare providers need training in these areas: instruction that involves looking at the provider's attitudes and behaviors regarding gender, sexuality, and touch. Until these subjects become a standard part of medical education, healthcare providers will be more likely to care for people in ways that could be inappropriate and even harmful and in ways that are at odds with the very purpose of healthcare.

PERSONAL EXPLORATIONS IN GENDER, SEXUALITY AND TOUCH

Everyone has certain limiting ideas and ingrained biases that shape the way we view the world. As we become aware of these prejudices, we can control and redirect them to better care for our patients.

It is important to acknowledge that we all have limiting ideas and ingrained biases that affect our perceptions. Figuring out what these ideas and biases are, and maintaining an awareness of what effects they might have, is the key to dealing with them rationally and appropriately. For instance, if you feel uncomfortable in the presence of one of your clients, it is helpful to understand why.

> *"The general western culture and its emphasis on autonomy, independence, separateness and privacy have resulted in restricting interpersonal physical touch to a minimum. America is a "low-touch culture."*
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> Zur Institute Website; "The General Significance of Touch"; July, 2020

Gender

Assignment # 4:

Take out a piece of paper or open a new document and answer the questions to determine your views on gender.

1. What is your gender identity? How do you feel about that?
2. What range of gender roles are you comfortable with in others?

    a. Do you feel comfortable around a very businesslike woman?
    b. Do you feel comfortable around a very nurturing man?
3. Do you appreciate someone who can comfortably shift from one gender role to another—in other words, with someone who is gender fluid?
4. How satisfying do you find your relationship with patients male, female or other?
5. What percentage of your clients of any gender do you believe are satisfied with you as a doctor? How many would directly tell you? How many would say they were satisfied on an anonymous questionnaire?
6. What is the percentage of male, female and other patients in your practice? Why do you think that is the case? Is it because of your gender? Is it related to your level of comfort with a certain gender? Is it due to your circle of contacts?
7. Which gender patients do you prefer caring for? Why?
8. How would you characterize your average male patients? How about your average female patients? What are your relationships generally like with each group?
9. How would you rate yourself as a healthcare provider for clients, in terms of respect, sensitivity, flexibility, openness, and being non- judgmental?
10. What changes need to be made in the way you care for patients? What kind of training or help will you need to make those changes?

Discussion

If you are a man, you may have characteristics that would be considered feminine in our culture—for example, qualities like nurturing and sensitivity. If you are a woman, you may have qualities generally considered masculine—for example, traits like independence and intellectualism. Merely being a man or a woman or other does not mean that you must adopt the roles generally prescribed for any gender. A mix of gender traits can create a balanced, more successful personality. It can also create a balanced, more successful healthcare provider. Besides, we should all have the chance to be ourselves.

Sexuality

Assignment # 5:

Take out a piece of paper or open a new document and answer the following questions to determine your views on sexuality.

1. How would you describe your views regarding sexuality? Are they liberal? Moderate? Conservative? Extreme?
2. How would you describe your personal sexual practices or your beliefs regarding sexual practices?
3. How do you feel about what others do sexually and with whom?
4. Do you believe that everyone should believe and behave as you do?
5. What fantasies do you have that you would like fulfilled? Do you have fantasies involving any of your patients?
6. Are your sexual beliefs, fantasies, or practices ever a problem in your practice? How

so?

7. Are your patients' beliefs, fantasies, or practices—as evident in how they act, what they tell you, or in what you suspect—ever a problem for you? How so?
8. Do you ever try to impose your ideas on your patients? On your staff?
9. What changes need to be made to enable you to care for all patients more appropriately?
10. What might you need to learn about sexuality in general, and about your own sexuality in particular?

Discussion

It is important to be aware of your own sexuality and sexual impulses because repressing such feelings won't make them go away. Consciously or unconsciously, they will affect your actions. You may go through the day thinking, "Wow! That patient is hot!" or "What I wouldn't do to get a piece of that action!" Perhaps it would be more useful to say to oneself, "I'm somewhat attracted to this patient; I'll have to be especially careful." This might mean asking a staff member to be near the exam or treatment room, keeping the door open or consulting with a life coach. Or we may even hire a therapist to discuss strategies about such attractions with our patients. We are in charge in our practice to create a healing environment. It would not be beneficial to do anything that might be misinterpreted or misunderstood by patients. Remember, there is a moment between thinking of taking an action and actually acting. In that moment, we have the potential to consider consequences. If we can take advantage of that or those moments, then we will have reached a high level of practice—a level at which the needs of the patients are put above our own needs. This is called a fiduciary responsibility, which is a legal term that requires a healthcare provider to put the needs of the patients ahead of the needs of the practitioner.

In many seminars we talk about this fiduciary responsibility and that this responsibility requires that we must show up in our practice in the very best physical, emotional and mental state possible. We talk about our needing to be like a healing machine. One that is rested, fed in the most nutritious way, exercised appropriately and has handled all of our own 'personal stuff,' so that we can be there 100% for all who come to us. This is the very definition of practicing at the highest level possible. When we can do that, we will be able to pick up on subtle messages and non-verbal behaviors of our patients and respond with sensitivity. We will also then achieve a level of practice that can bring great joy and satisfaction. We do not want to end up giving the impression to a patient that we are interested in them or that we have any ulterior agendas.

It also is important to be aware of your sexual attitudes, biases and stereotypes you may consciously or unconsciously hold, because only then can you prevent them from interfering with patient care. As a caregiver, all of us would be wise to examine all beliefs and attitudes that could interfere in our ability to care for patients without judgment, which will be easier when we have examined ours.

We've spent quite a bit of time discussing many aspects of touch. In our training, there may or may not have been enough emphasis on the impact of our touch on our patients. We would like to focus on our own history with touch below.

Assignment # 6

Take out a piece of paper or open a new document and write down the answers to the following questions.

1. What is your family history when it comes to touch?
2. Was there a lot of touching?
3. Was there little touching?
4. How comfortable were you with touch as you were growing up?
5. Did you consider your personal history with touch when you were considering becoming a healthcare provider?
6. What, if any changes, will you consider making in your practice regarding touch?

Review

The purpose of our exploration of touch is to bring awareness to something we do almost automatically and to consider the impact of our touch on others. Then we considered the history and potential impact of our touch on our patients. Every practitioner will benefit from explaining beforehand what they will do and why and then ask for consent to touch from each patient. It is also a good idea to ask questions about comfort and if they have any questions about what we are doing. This is particularly important the first time we will be touching a new patient. It is always wise to do a review of procedures with returning patients until we have established their comfort with our procedures.

References

[1]To Touch or Not to Touch: Exploring the Myth of Prohibition on Touch in Psychotherapy and Counseling Clinical, Ethical & Legal Considerations; Zur Institute Website; Ofer Zur, Ph.D. & Nola Nordmarken, MFT; 2017

[2]Touching: The Human Significance of the Skin; New York: Columbia University Press, 1971, 6.

[3] George Howe Colt, The Magic of Touch: Massage's Healing Powers Make it Serious Medicine," Life (August 1997), 62.

[4ibid.] Decoding Touch: New Research Points to Potential Therapy for Abnormal Touch Sensitivity in Autism Spectrum Disorders; Pratiba Gopalakrishna and Ekaterina Pesheva; August 8, 2019; Harvard Medical School website.